

The Mock Trial in Psychiatric Staff Education

Stewart Levine, MD and Henry Pinsker, MD

The mock trial is an important educational technique that has seldom been reported in the medical literature. In this paper we describe the evolution of mock trials as a regular component in the educational program for our multidisciplinary staff. The mock trial is not only an excellent strategy for teaching about the interface between psychiatry and the law, but also for teaching about malpractice, documentation, and medical reasoning. The most effective presentation used an actual case from our facility, practicing attorneys, and an experienced judge in a condensed version of a trial.

The mock trial is a valuable educational technique that does not appear to be widely utilized in medical or psychiatric education. A survey of the literature on the teaching of legal medicine in medical schools by Beresford¹ mentioned moot court demonstration in only four programs of 79. Sadoff *et al.*² did not mention the use of mock trials in their 1974 survey. There was no mention of trials in a survey of medical education by Dornette³ in 1971, or surveys of psychiatric education by Barr and Suarez⁴ or Stoller.⁵ Dunlop⁶ described a moot court that used a "created" case involving involuntary hospitalization and involuntary treatment. Psychiatric residents and

law students were involved. Cohen *et al.*⁷ wrote about a mock trial that used attorneys as part of a seminar for psychiatry residents, pediatricians, and junior faculty. They utilized a fictitious case modeled on a real case that had recently been completed. Randolph-Prince⁸ wrote about an imaginary case for teaching general health-related issues. Langford⁹ discussed use of a moot court in teaching bioethics to medical and nursing students, using an actual case that had been altered. Actual attorneys and a judge participated.

The mock trial is a distinctive educational technique that deserves to be more widely employed. It is useful for teaching health and mental health professionals not only about the interface between medicine and the law, but also about many ethical and clinical issues.

The issues that come up most frequently in general hospital psychiatry

Dr. Levine is unit chief, Department of Psychiatry, Beth Israel Medical Center, New York, NY and assistant professor of psychiatry, Mount Sinai School of Medicine, New York, NY. Dr. Pinsker is senior supervising psychiatrist, Department of Psychiatry, Beth Israel Medical Center, New York, NY and clinical professor of psychiatry, Mount Sinai School of Medicine, New York, NY. Address correspondence to: Dr. Levine, Department of Psychiatry, Beth Israel Medical Center, New York, NY 10003.

are involuntary admission, involuntary treatment, release, and assessment of capacity. Threats of malpractice suits or punitive action by a regulatory agency is often discussed. Testimony of psychiatrists about criminal responsibility in important cases attracts media attention, but this is a specialized concern. The most effective courtroom drama for education in general psychiatry is one which allows members of the audience to identify easily with the defendant. In this paper we describe our experiences with different approaches to selection of actors and different forms of case material in staging the mock trials as a regular component of the educational program for students and trainees, and for the entire multidisciplinary staff of the Department of Psychiatry at Beth Israel Medical Center. (This is a major urban medical center, affiliated with The Mount Sinai School of Medicine of the City University of New York.)

The Mock Trial

The following is a description of our most recent trial, including a description of the case, the participants, the setting, and the trial itself.

The case involved a patient who had committed suicide several weeks after discharge. When we conducted a mortality review we were able to trace out a sequence of events that made the suicide understandable, we concluded that a suit was unlikely because there seemed no doubt that the patient was ready for discharge, that discharge planning had been adequate, and because events in the patient's life subsequent to discharge

may have played an important part in her decision to suicide. However, the focus of a mortality review or "psychological autopsy" is quite different from that of a trial. In it we search for clues that were missed, and we try to create a cause and effect sequence to explain the patient's action. We decided that the conclusions from the mortality review could be used as the plaintiff's case in a mock trial.

In our experience, within the time frame allowed and considering the attention span of the audience, a small cast was optimum: a defendant, an expert for the plaintiff, and the plaintiff. The attorneys were from the staff of The Mental Hygiene Legal Service, a state agency that performs many advocacy services for patients. The local director of MHLS provided attorneys who were not assigned to our hospital, and he recruited a veteran judge from the New York Supreme Court (the first tier in the court system).

In this case, as in previous trials, the psychiatrist assigned the role of plaintiff's expert was the psychiatrist who had supervised the patient's care in the hospital, i.e., the individual who, should there be a suit, would be the defendant. Most people under these circumstances are preoccupied with their defense, but being forced to look at the case from the opposite point of view encourages thorough consideration of all the possibilities.

The role of the defendant was played by a senior resident other than the one who had treated the patient. We had considered using the resident who had

Mock Trial in Staff Education

been involved, on the grounds that the treatment staff is able to tolerate exposure at a morbidity conference, but we concluded that being attacked in an adversary proceeding would be more threatening than participating in a morbidity conference.

The trial was held in a large auditorium, with three hours reserved, scheduled far enough ahead so that most staff could rearrange their appointments. The audience included senior and junior psychiatric staff, residents, nurses, social workers, students in these disciplines, medical students, members of risk management, and quality assurance staffs.

Prior to the trial itself, the patient's extensive clinical record was copied, identifying information removed, and distributed to the witnesses and attorneys. The volunteer attorneys invested significant time reviewing the records and meeting with their witnesses to plan the testimony, as in a real case.

The plaintiff's case rested on three issues: negligence in treatment planning; negligence in diagnosis (i.e., assessment of risk of suicide); and, if negligence was found, proximate cause as to the negligence and the suicide.

Examination of the witnesses focused on several issues. The patient's history prior to this admission, as documented in the chart, was reviewed through examination of the witnesses. This history included suicidal thoughts and attempts, as well as two prior psychiatric hospitalizations at our facility. The experts on both sides were called on to explain how this history would influence their thinking regarding the most recent episode.

The attorneys also looked at the course of the present hospitalization, asking each witness what they thought about the fact that this patient, who was suicidal when she entered the hospital, totally denied suicidal thoughts within just a few days. A detailed examination of the documentation took place, asking both resident and experts questions based on this material. Both sides were asked their thinking regarding the patient's diagnosis, based on the material in the chart. Discharge planning proved to be the focus of the most heated questioning. The plan called for return to her private psychiatrist and to a day treatment program, because the concern was that she would have nothing to do during the day and that this would lead, as it had in the past, to loneliness and depression. At the time of discharge, she refused to go to the day program and was discharged to be followed only by her psychiatrist. The attorneys directed their questioning to the rationale for discharging the patient without the after-care plan that had been thought necessary, and whether this was negligent practice.

After both sides had completed their questioning, the judge explained the legal concepts of malpractice and what would constitute sufficient evidence for the jury to find in favor of the plaintiff's case. He explained the legal concept of proximate cause and how it related to the issues of this case.

At the end of the trial, the audience was asked to form groups of six, each to reach a verdict. After a brief period of excited deliberation, four juries found negligence in treatment planning, but

not in diagnosis. Two juries did not find negligence in either treatment planning or diagnosis. No jury found that the negligence was proximate cause of the death.

After the trial, several comments were obtained from those in the audience regarding their experience of this exercise. Some noted that they had learned of the importance of careful documentation in medical charts, while others were impressed how attorneys would go over medical records with great detail in examining witnesses.

Previous Trials

We will briefly discuss our past experience with mock trials, and then compare them with our most recent, discussed above.

Our first case involved a bad outcome involving a patient of our department. Within a few days of discharge, the patient sustained serious injury in a suicide attempt by jumping from a building. Testimony at the mock trial focused on clinical issues involving the severity of symptoms and evidence of impairment at the time the patient was discharged.

The second case used for a mock trial involved extrapolation from sparse facts. A patient who had been brought to the hospital as suicidal was released from the emergency room after having been evaluated by a resident. When the case was reviewed we felt that the resident had been superficial in his evaluation of the patient, so for teaching purposes of the mock trial, we invented a story of subsequent suicide. The trial consisted largely of testimony by the psychiatric

experts about what is or is not proper practice regarding patients who state they are suicidal. The only available clinical data were that of the emergency room chart.

Our third mock trial was based on the landmark case of *Petersen v. State*.¹⁰ From the text of the appellate court decision, a clinical transcript was prepared by the authors. The issues of this case involve the decision by a psychiatrist not to seek an additional involuntary commitment for a patient who, subsequently, five days after discharge from the hospital, caused serious injury to the plaintiff in a car accident. Direct and cross examination in this trial focused on questions of diagnosis (since there was a history of both schizophrenia and drug use in this patient), treatment issues, and discharge planning.

Differences Between Mock Trials

It is important to briefly mention here what differences there have been between the mock trials we have held in our department. In our first mock trials, the attorneys were senior psychiatrists who had considerable courtroom experience as expert witnesses, and one of the medical center's attorneys played the role of judge. Expert witnesses were residents and attending physicians. In the most recent trial, as noted above, actual attorneys and a judge were involved. It is clear now that the psychiatrists who played the role of lawyers in our earlier trials lacked the courtroom competitiveness of practicing lawyers in examination of witnesses and tended to focus on important clinical issues, as they would

Mock Trial in Staff Education

in a clinical conference. The true lawyers, on the other hand, were far more alert to inconsistencies and discrepancies in the record and in the testimony. The education of attorneys involves training in the adversary role, in which they are taught to question and challenge, whereas physicians are taught to understand patients' problems.⁷

In regard to the setting, the first mock trials were incorporated into the ongoing educational schedule. Since the largest scheduled block of time was 90 minutes, considerable truncation of the material was necessary. For the most recent trial, three hours were set aside to allow for a fuller exposition of the case.

We found that the most effective mock trial utilized a real case from our own department. Members of the audience could easily put themselves in the shoes of the doctor who was being sued. Most could imagine themselves having a similar patient and coming to the same decision. Since the crux of a malpractice case is the physician's actions, we believe it is better to create a bad outcome as a fictitious appendix to a real case than to try to create a case. Only by this strategy is it possible to have a case record of sufficient size that it contain many observations, details about the treatment, and the rationale for decisions. Without a large body of information, it may be necessary to allow the defendant to describe his undocumented actions. This does happen in a real trial, but to allow this in a mock trial allows history to be invented. If there are not enough data to bind the participants, there is nothing to

govern the direction of questions and answers.

Discussion

The use of a mock trial as a teaching device in medical and mental health education has rarely been reported. We feel that it is a powerful tool for teaching about the interface between medicine and the law, and also for teaching about diagnosis, treatment planning, and documentation.

Malpractice cases effectively demonstrate the importance of accurate documentation of diagnosis and treatment planning, and how examination of what does and does not appear in the chart is used to assess the physician's practice of medicine. In our experience not only do these cases demonstrate the issues clearly, but they also hold the attention of the audience most effectively. In addition to malpractice cases, mock trials can be based on commitment procedures, involuntary treatment, competency, and ethical issues involving physician behavior. We have not utilized involuntary hospitalization and treatment because our residents are able to participate in actual cases involving their patients. A mock regulatory agency hearing would be extremely useful, but attorneys and psychiatrists who have had experience with them are not readily available.

To be effective, the mock trial requires extensive preparation and a block of time longer than the usual case conference or class. There may be a reluctance to use the actual clinical record when a case has a bad outcome. With proper

instruction about the importance of avoiding public or casual discussion, the educational benefit of using a timely case is so great that it should be done. The issue of discoverability has been discussed with our hospital's attorneys. They conclude that since no names are used, nor a transcript of the case made, and for the most part, only psychiatric staff are aware and attend the trial, discoverability is not a concern. Further, our department considers the mock trial both an educational and a quality assurance activity, and is, therefore, a peer review process.

The adversary format, by going counter to the supportive, collegial response one expects within one's own profession or within a staff meeting, directs attention to the articulation of medical reasoning and to the physician's duty to the patient. Once having had experience during a mock trial with these issues, the psychiatric resident may have less anxiety when actually faced with them.

References

1. Beresford HR: The teaching of legal medicine in medical schools in the United States. *J Med Educ* 46:401-4, 1971
2. Sadoff RL, Thrasher JW, Gottlieb DW: Survey of teaching programs in law and psychiatry. *Bull Am Acad Psychiatry Law* 2:67-72, 1974
3. Dornette WHL: Interdisciplinary education in medicine and law in American medical colleges. *J Med Educ* 46:389-400, 1971
4. Barr NI, Suarez JM: The teaching of forensic psychiatry in law schools, medical schools and psychiatric residencies in the United States. *Am J Psychiatry* 122:612-6, 1965
5. Stoller RJ: The teaching of forensic psychiatry in American and Canadian medical centers. *Am J Psychiatry* 115:150-3, 1958
6. Dunlop SR: Using a moot court experience in the education of psychiatric residents. *Bull Am Acad Psychiatry Law* 6:423-32, 1978
7. Cohen SN, Folberg HJ, Sack WH, Lingas J: Meeting a training need: an interdisciplinary seminar of family law and child psychiatry. *Bull Am Acad Psychiatry Law* 5:336-43, 1977
8. Randolph-Prince A: Teaching critical thinking through the mock trial. *J School Health* 50:423-4, 1990
9. Langford MJ: The moot court in teaching bioethics. *Nurse Educ Today* 10:24-30, 1990
10. *Petersen v. State*, 671 P. 2d 230 (Wash. 1983)

ERRATUM

Galley proofs of the article "Treatment Boundary Violations: Clinical, Ethical, and Legal Considerations" (*Bull Am Acad Psychiatry Law* 20:269-88, 1992) by Robert I. Simon, M.D., were not sent to the author because of an oversight. As a consequence, typographical errors in the galley proofs remained uncorrected. In addition, the case of *Omer v. Edgren* cited in the text was misspelled. We regret these errors.